

# DENTAL & MEDICAL HISTORY

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: \_\_\_\_\_ PATIENT FIRST NAME: \_\_\_\_\_

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Date of last dental visit \_\_\_\_\_  
 Former dentist \_\_\_\_\_ Date of last dental x-rays \_\_\_\_\_

Please check if you have/had:	Yes	No		Yes	No	
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Head, neck, jaw pain, or aches	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>	
Burning sensation on tongue	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please explain _____
Chew on one side of mouth	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cigarette, pipe, or cigar smoking	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smokeless tobacco	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Oxide	<input type="checkbox"/>	<input type="checkbox"/>	
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>	
Food collection between teeth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to pressure or irritants (cold, heat, sweets)	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had trouble from previous dental care?
Clench or grind teeth	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss? _____			<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain _____
Growths or sore spots in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush? _____			_____
Gums swollen, tender or bleeding	<input type="checkbox"/>	<input type="checkbox"/>				_____

## MEDICAL HISTORY

Physician's name \_\_\_\_\_ Date of last visit \_\_\_\_\_  
 Physician's address \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Have you had any serious illnesses or operations Yes  No  If yes, please describe \_\_\_\_\_  
 Have you ever had a blood transfusion Yes  No  If yes, give approximate dates \_\_\_\_\_  
 (Women) Are you pregnant? Yes  No  Due date \_\_\_\_\_ Nursing? Yes  No  Taking birth control pills? Yes  No

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Slow healing wounds	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis type _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Required Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	Any immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth on head/neck	<input type="checkbox"/>	<input type="checkbox"/>
Have you used steroids	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Date of last episode _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally with operations or surgery	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss, unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease, clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Do you consume alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently under the care of a Physician?	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic/sensitive to Latex?	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatments	<input type="checkbox"/>	<input type="checkbox"/>	Allergic to Penicillin, Aspirin, or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please specify _____		
Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	List any medications that you are taking:		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	_____		

## AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_